

LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
PAYOR FINANCIAL INFORMATION

CONFIDENTIAL CLIENT INFORMATION
See W & I Code, Section 5328

CLIENT INFORMATION

1	CLIENT NAME	SS #	CLIENT ID #
2	MAIDEN NAME	DOB	MARITAL STATUS M S D W SP SPOUSE NAME

THIRD PARTY INFORMATION

3	NO THIRD PARTY PAYOR <input type="checkbox"/>			
4	MEDI-CAL <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-CAL COUNTY CODE /AID CODE/ CLAIM #	MEDI-CAL PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO REFERRED FOR ELIGIBILITY <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE REFERRED
5	SHARE OF COST <input type="checkbox"/> YES <input type="checkbox"/> NO	SOC AMT \$	SSI PENDING <input type="checkbox"/> YES <input type="checkbox"/> NO	SSI APPLICATION DATE IF MEDI-CAL/SSI ELIGIBLE BUT NOT REFERRED, STATE REASON
6	MEDI-CAL HMO <input type="checkbox"/> YES <input type="checkbox"/> NO	CALWORKS <input type="checkbox"/> YES <input type="checkbox"/> NO	AB3632 <input type="checkbox"/> YES <input type="checkbox"/> NO	GROW <input type="checkbox"/> YES <input type="checkbox"/> NO
7	MEDICARE <input type="checkbox"/> YES <input type="checkbox"/> NO	MEDI-GAP <input type="checkbox"/> YES <input type="checkbox"/> NO	CHAMPUS <input type="checkbox"/> YES <input type="checkbox"/> NO	VET/ADM <input type="checkbox"/> YES <input type="checkbox"/> NO
8	NAME OF CARRIER		GROUP/POLICY/ID #	NAME OF INSURED
9	CARRIER ADDRESS			ASSIGNMENT/RELEASE OF INFORMATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO

PAYOR REFERENCES (CLIENT OR RESPONSIBLE PERSON)

10	NAME OF PAYOR	RELATION TO CLIENT	DOB	MARITAL STATUS M S D W SP	PAYOR CDL/CAL ID
11	ADDRESS	CITY	STATE	ZIP CODE	TEL #
12	SOURCE OF INCOME: <input type="checkbox"/> SALARY <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> UNEMPLOYMENT INSURANCE <input type="checkbox"/> DISABILITY INSURANCE <input type="checkbox"/> SSI <input type="checkbox"/> GR <input type="checkbox"/> VA <input type="checkbox"/> Other Public Assistance <input type="checkbox"/> IN-KIND <input type="checkbox"/> UNKNOWN <input type="checkbox"/> OTHER: _____				PAYOR SS #
13	EMPLOYER		POSITION		IF NOT EMPLOYED, DATE LAST WORKED
14	EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
15	SPOUSE	ADDRESS (Include City, State & Zip Code)			SPOUSE'S SS #
16	SPOUSE'S EMPLOYER		POSITION		IF NOT EMPLOYED, DATE LAST WORKED
17	SPOUSE'S EMPLOYER'S ADDRESS (Include City, State & Zip Code)				TEL #
18	NEAREST RELATIVE/RELATIONSHIP		ADDRESS (Include City, State & Zip Code)		TEL #

UMDAP LIABILITY DETERMINATION

<p>19 LIQUID ASSETS</p> <p>Savings \$ _____</p> <p>Checking Accounts \$ _____</p> <p>IRA, CD, Market value of stocks, bonds and mutual funds \$ _____</p> <p>TOTAL LIQUID ASSETS \$ _____</p> <p>Less Asset Allowance \$ _____</p> <p>Net Asset Valuation \$ _____</p> <p>Monthly Asset Valuation (Divide Net Asset by 12) \$ _____</p> <p>VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>20 ALLOWABLE EXPENSES</p> <p>Court ordered obligations paid monthly \$ _____</p> <p>Monthly child care payments (necessary for employment) \$ _____</p> <p>Monthly dependent support payments \$ _____</p> <p>Monthly medical expense payments \$ _____</p> <p>Monthly mandated deductions from gross income for retirement plans. (Do not include Social Security) \$ _____</p> <p>Total Allowable Expenses \$ _____</p> <p>VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>21 ADJUSTED MONTHLY INCOME</p> <p>Gross Monthly Family Income</p> <p>Self/Payor \$ _____</p> <p>Spouse \$ _____</p> <p>Other \$ _____</p> <p>TOTAL \$ _____</p> <p>Add monthly asset valuation \$ _____</p> <p>TOTAL \$ _____</p> <p>Subtract total expenses \$ _____</p> <p>Adjusted Monthly Income \$ _____</p> <p>VERIFICATION OBTAINED <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		
22	Number Dependent on Adjusted Monthly Income	ANNUAL LIABILITY	ANNUAL CHARGE PERIOD FROM TO	Payment Plan \$ _____ per month for _____ months.
23	PROVIDER OF FINANCIAL INFORMATION Name and Address (If Other Than Patient or Responsible Person)			

OTHER

24	PRIOR MH TREATMENT (Only applicable to current Annual Charge Period) <input type="checkbox"/> YES <input type="checkbox"/> NO WHERE:	FROM	TO	PRESENT ANNUAL LIABILITY BALANCE
25	ANNUAL LIABILITY ADJUSTED BY	DATE		REASON ADJUSTED
	ANNUAL LIABILITY ADJUSTMENT APPROVED BY	DATE		
26	An explanation of the UMDAP liability was provided. SIGNATURE OF INTERVIEWER			PROVIDER NAME AND NUMBER
27	I affirm that the statements made herein are true and correct to the best of my knowledge and I agree to the payment plan as stated on line 22 SIGNATURE OF CLIENT OR RESPONSIBLE PERSON DATE			